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Section

520.001: Introduction to General Financial Requirements

(A) 130 CMR 520.000 describes the rules governing financial eligibility for MassHealth. 130 CMR 520.000 is based on financial responsibility, countable income, and countable assets.

(B) The methods for the calculation of the countable-income amount, the deductible, and the income standards used in the determination of eligibility are also explained in 130 CMR 520.000.

520.002: Financial Responsibility

(A) Community Residents.

(1) Spouses Living Together. In the determination of eligibility for MassHealth, the total countable-income amount and countable assets of the individual and the spouse who are living together are compared to an income standard and asset limit, unless one spouse is covered by MassHealth under a home- and community-based services waiver, as described in 130 CMR 519.007(B).

(2) Spouses Living Apart. When spouses live apart for reasons other than admission to a medical institution, their assets and income are considered mutually available only through the end of the calendar month of separation.

(B) Residents of Medical Institutions.

(1) Spouses Living Together. When spouses live in the same long-term-care facility, the income and assets are not mutually available.

(2) One Spouse Institutionalized.

(a) If only one spouse is a resident of a medical institution who is expected to remain in the facility for 30 days or more, the community spouse's income is not counted in the determination of eligibility for the institutionalized spouse. The institutionalized spouse may provide for the maintenance needs of the community spouse in accordance with 130 CMR 520.026(B).

(b) The countable assets of both spouses must be evaluated and a spousal share established in accordance with 130 CMR 520.016(B).

(3) Institutionalized Child. When a child under age 18 lives in a medical institution, the income and assets of the parents are considered available only through the end of the calendar month of separation.

520.003: Asset Limit

(A) The total value of countable assets owned by or available to individuals applying for or receiving MassHealth Standard, Essential, or Limited may not exceed the following limits:

(1) for an individual — $2,000; and

(2) for a couple living together in the community where there is financial responsibility according to 130 CMR 520.002(A)(1) — $3,000.

(B) The total value of countable assets owned by or available to individuals applying for or receiving MassHealth Senior Buy-In, as described in 130 CMR 519.010, or MassHealth Buy-In, as described in 130 CMR 519.011, may not exceed the following limits:

(1) for an individual — $4,000; and

(2) for a couple living together in the community where there is financial responsibility according to 130 CMR 520.002(A)(1) — $6,000.

(C) The treatment of a married couple's assets when one spouse is institutionalized is described in 130 CMR 520.016(B).

520.004: Asset Reduction

(A) Criteria.

(1) An applicant whose countable assets exceed the asset limit of MassHealth Standard, Essential, or Limited may be eligible for MassHealth:

(a) as of the date the applicant reduces his or her excess assets to the allowable asset limit without violating the transfer of resource provisions for nursing-facility residents at 130 CMR 520.019(F); or

(b) as of the date, described in 130 CMR 520.004(C), the applicant incurs medical bills that equal the amount of the excess assets and reduces the assets to the allowable asset limit within 30 days after the date of the notification of excess assets.

(2) In addition, the applicant must be otherwise eligible for MassHealth.

(B) Evaluating Medical Bills. MassHealth does not pay that portion of the medical bills equal to the amount of excess assets. Bills used to establish eligibility:

(1) cannot be incurred before the first day of the third month prior to the date of application as described at 130 CMR 516.002;

(2) must not be the same bills or the same portions of the bills that are used to meet a deductible based on income; and

(3) for MassHealth Essential, must be incurred on or after the effective date of the coverage type.

(C) Date of Eligibility. The date of eligibility for otherwise eligible individuals described at 130 CMR 520.004(A)(1)(b) is the date that his or her incurred allowable medical expenses equaled or exceeded the amount of his or her excess assets.

(1) If after eligibility has been established, an individual submits an allowable bill with a medical service date that precedes the date established under 130 CMR 520.004(C), MassHealth readjusts the date of eligibility.

(2) In no event will the first day of eligibility be earlier than the first day of the third month before the date of the application, if permitted by the coverage type.

(D) Verification. MassHealth requires the applicant to verify that he or she incurred the necessary amount of medical bills and that his or her excess assets were reduced to the allowable asset limit within required timeframes.

520.005: Ownership of Assets

(A) General. Assets owned exclusively by an applicant or member and the spouse are counted in their entirety when determining eligibility for MassHealth, except when assessing assets in accordance with 130 CMR 520.016.

(B) Joint Ownership of Assets, Other Than Bank Accounts. Any asset, other than a joint bank account, jointly owned by two or more individuals, is presumed to be owned in equal shares and counted proportionately unless a different distribution of ownership is verified or unless assets are being assessed in accordance with 130 CMR 520.016. When such a different distribution of ownership is verified, MassHealth attributes the countable value of the assets to the applicant or member or the spouse in proportion to the ownership interest.

(C) Joint Bank Accounts.

(1) Bank accounts are defined at 130 CMR 520.007(B)(1).

(2) When the applicant or member is a joint owner of a bank account, the entire amount on deposit is considered available to the applicant or member, except when assessing assets in accordance with 130 CMR 520.016.

(3) If the applicant or member claims partial ownership of the funds in the joint account, he or she must verify the amount owned by each joint depositor. When such a partial ownership is verified, the countable value of the assets is attributed to each owner in proportion to the ownership interest.

(4) The applicant or member may transfer the funds owned by him or her into an account that accurately reflects his or her ownership interest. MassHealth does not consider such a transfer of assets to make oneself eligible for MassHealth if the transfer is completed within 30 days after written notification by MassHealth of this requirement, except in the case of a community spouse as described at 130 CMR 520.016 who is allowed 90 days to make the transfer.

(D) Verifications. Individual or joint ownership of any countable asset must be verified by a written document providing reasonable evidence of ownership. The Division determines whether a verification is acceptable in accordance with 130 CMR 520.007(B)(3) and 130 CMR 520.005(D). Acceptable verification includes, but is not limited to, the following:

(1) a title;

(2) a purchase contract;

(3) documents establishing ownership of joint bank accounts that demonstrate the following:

(a) the origin of the funds in a joint bank account, who opened the account, or whose money was used to open the account;

(b) federal and state tax records as to which joint account holders pay the tax on interest credited to the account as income;

(c) records of who makes deposits and withdrawals and, if appropriate, how withdrawn funds are spent;

(d) any evidence of written or oral agreements made between the parties at the time of the creation of the account;

(e) evidence of age, relationship, physical or mental condition, or place of residence of the co-holders when the applicant or member states that he or she does not own the account but is listed as a co-holder solely as a convenience to the other co-holder to conduct bank transactions on his or her behalf; and

(f) why the applicant or member is listed on the account;

(4) certification of ownership;

(5) financial-institution records indicating the establishment of an account that accurately reflect the ownership interest of funds from the joint account;

(6) other documentation that indicates ownership, asset value, and restrictions on access;

(7) a notarized affidavit, sworn to under penalty of perjury, signed by all owners of the asset, and attesting to the distribution of ownership; or

(8) the self-declaration of the individual who is applying solely for MassHealth Buy-In, as described at 130 CMR 519.011(B). The Division may, at its discretion, request additional verification.

520.006: Inaccessible Assets

(A) Definition. An inaccessible asset is an asset to which the applicant or member has no legal access. The Division does not count an inaccessible asset when determining eligibility for MassHealth for the period that it is inaccessible or is deemed to be inaccessible under 130 CMR 520.006.

(B) Examples of Inaccessible Assets. Inaccessible assets include, but are not limited to:

(1) property, the ownership of which is the subject of legal proceedings (for example, probate and divorce suits); and

(2) the cash-surrender value of life-insurance policies when the policy has been assigned to the issuing company for adjustment.

(C) Date of Accessibility. The Division considers accessible to the applicant or member all assets to which the applicant or member is legally entitled:

(1) from the date of application or acquisition, whichever is later, if the applicant or member does not meet the conditions of 130 CMR 520.006(C)(2)(a) or (b); or

(2) from the period beginning six months after the date of application or acquisition, whichever is later, if:

(a) the applicant or member cannot competently represent his or her interests, has no guardian or conservator capable of representing his or her interests, and the eligibility representative (which may include a provider) of such applicant or member is making a good-faith effort to secure the appointment of a competent guardian or conservator; or

(b) the sole trustee of a Medicaid Qualifying Trust, under 130 CMR 520.022(B), is one whose whereabouts are unknown or who is incapable of competently fulfilling his or her fiduciary duties, and the applicant or member, directly or through an eligibility representative (which may include a provider), is making a good-faith effort to contact the missing trustee or to secure the appointment of a competent trustee.

520.007: Countable Assets

Countable assets are all assets that must be included in the determination of eligibility. Countable assets include assets to which the applicant or member or the spouse would be entitled whether or not these assets are actually received when failure to receive such assets results from the action or inaction of the applicant, member, spouse, or person acting on his or her behalf. In determining whether or not failure to receive such assets is reasonably considered to result from such action or inaction, the Division considers the specific circumstances involved. The applicant or member and the spouse must verify the total value of countable assets. However, if he or she is applying solely for MassHealth Buy-In, as described at 130 CMR 519.011(B), verification is required only upon Division request. 130 CMR 520.007 also contains the verification requirements for certain assets. The assets the Division considers include, but are not limited to, the following.

(A) Cash.

(1) Definition. Cash is defined as currency, checks, and bank drafts in the possession of or available to the applicant, member, or spouse.

(2) Verification. The applicant's or member's declaration on the application or redetermination form stating the amount of cash available to him or her is sufficient verification.

(B) Bank Accounts.

(1) Requirements. Bank accounts are defined as deposits in a bank, savings and loan institution, credit union, or other financial institution. Bank accounts may be in the form of savings, checking, or trust accounts, term certificates, or other types of accounts.

(2) Determination of Ownership and Accessibility. The Division considers funds in a bank account available only to the extent that the applicant or member has both ownership of and access to such funds. The Division determines the ownership of and access to the funds in accordance with 130 CMR 520.005 and 520.006.

(3) Verification of Account Balances. The Division requires verification of the current balance of each account at application, during eligibility review, and at times of reported change.

(a) Noninstitutionalized individuals excluding the individuals described at 130 CMR 519.007(B) must verify the amount on deposit by bank books or bank statements that show the bank balance within 45 days of the date of application or the date that the eligibility review is received in a MassHealth Enrollment Center or outreach site.

(b) Nursing-facility residents as described at 130 CMR 515.001 must verify the amount on deposit by bank books or bank statements that show the current balance and account activity during the look-back period.

(c) If during an eligibility review the member states either orally or in writing that an account other than a checking account contains a balance of $25 or less, the Division does not require verification provided that, in combination with other countable assets, it would not affect continued eligibility.

(d) If lack of either access to or ownership of funds in an account is verified, the Division will not consider the funds a countable asset.

(C) Individual Retirement Accounts, Keogh Plans, Pension Funds, and Annuities.

(1) Individual Retirement Accounts. An Individual Retirement Account (IRA) is a tax-deductible savings account that sets aside money for retirement. Funds in an IRA are counted as an asset in their entirety less the amount of penalty for early withdrawal.

(2) Keogh Plans. A Keogh Plan is a retirement plan established by a self-employed individual. A Keogh Plan may be established for the self-employed individual alone or for the self-employed individual and his or her employees. If the Keogh Plan was established for the self-employed individual alone, the funds in the Plan are counted as an asset in their entirety less the amount of penalty for early withdrawal. If the Keogh Plan was established for employees other than the spouse of the applicant or member, the Division does not count the funds as an asset.

(3) Pension Funds. A pension fund is a retirement plan established by an employer to provide benefit payments to employees upon retirement or disability. Pension funds that are being set aside by an individual's current employer are not countable as an asset. Pension funds from an individual's former employer are countable in their entirety less any penalties for withdrawal provided such funds are accessible. (See 130 CMR 520.006.)

(4) Annuities. Payments from an annuity are countable income in accordance with 130 CMR 520.009. If the annuity can be converted to a lump sum, the lump sum, less any penalties or costs of converting to a lump sum, is a countable asset. Purchase of an annuity is a disqualifying transfer of assets for nursing-facility residents as defined at 130 CMR 515.001 in the following situations:

(a) when the beneficiary is other than the applicant, member, or spouse;

(b) when the beneficiary is the applicant, member, or spouse and when the total present value of projected payments from the annuity is less than the value of the transferred asset (purchase price). In this case, the Division determines the amount of the disqualifying transfer based on the actuarial value of the annuity compared to the beneficiary's life expectancy using the life-expectancy tables as determined by the Division, giving due weight to the life-expectancy tables of institutions in the business of providing annuities;

(c) when the terms of the annuity postpone payment beyond 60 days, the Division will treat the annuity as a disqualifying transfer of assets until the payment start date; or

(d) when the terms of the annuity provide for unequal payments, the Division may treat the annuity as a disqualifying transfer of assets. Commercial annuity payments that vary solely as a result of a variable rate of interest are not considered unequal payments under 130 CMR 520.007(C)(4)(d).

(D) Securities. Securities include, but are not limited to, stocks, bonds, options, futures contracts, debentures, mutual funds including money-market mutual funds, promissory notes, and other financial instruments. Tradable securities are valued at the most recent closing-bid price, and nontradable securities are valued at current equity value. A security for which there is no market value or that is inaccessible in accordance with 130 CMR 520.006 is noncountable.

(E) Cash-Surrender Value of Life-Insurance Policies.

(1) The cash-surrender value of a life-insurance policy is the amount of money, if any, that the issuing company has agreed to pay the owner of the policy upon its cancellation. An individual may adjust the cash-surrender value of life insurance to meet the asset limit. The Division will consider the cash-surrender-value amount an inaccessible asset during the adjustment period.

(2) If the total face value of all countable life-insurance policies owned by the applicant, member, or spouse exceeds $1,500, the total cash-surrender value of all policies held by that individual is countable. The Division does not count the face value of burial insurance and the face value of life-insurance policies not having cash-surrender value (for instance, term insurance) in determining the total face value of life-insurance policies. Burial insurance is insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses, funeral expenses, or both of the insured.

(F) Vehicles as Countable Assets.

(1) Requirements. In determining the assets of an individual (and the spouse, if any), the countability of a vehicle is determined as follows.

(a) One vehicle per household is noncountable regardless of its value if it is for the use of the individual or the spouse living in the community.

(b) For an unmarried institutionalized individual, one vehicle is noncountable if:

(i) it is used to access medical treatment of a specific or regular medical problem;

(ii) it is modified for operation by or transportation of a handicapped person; or

(iii) its equity value does not exceed $4,500; if the equity value exceeds $4,500, the excess is countable toward the individual's asset limit.

(c) The equity value of all other vehicles is a countable asset.

(2) Exemption.

(a) Three-Month Exemption. The Division does not count the value of nonexempt vehicles exceeding the asset limit for three calendar months provided the applicant or member signs an agreement with the Division to dispose of the vehicles at fair-market value.

(b) Additional Exemption for Good Cause. The Division may grant an additional three-month extension if the disposition was prevented by an event beyond the control of the individual who was making a good-faith effort to dispose of the property during the initial three-month period.

(c) Proceeds. The proceeds from the sale of the vehicle after payment of loans or other encumbrances and expenses of sale such as taxes, fees, and advertising costs are a countable asset in the month received and in subsequent months. The equity value of a vehicle that has not been sold three calendar months after the date of the written agreement (or six calendar months after the date of the written agreement if an extension has been granted) is a countable asset.

(d) Equity Value. Equity value is determined by subtracting the balance of any loans, liens, encumbrances, and expenses of sale, such as taxes, fees, and advertising costs, from the fair-market value of the vehicle.

(e) Fair-Market Value. Fair-market value is the price for which the vehicle will sell on the open market.

(f) Verification. The applicant or member must verify the fair-market value and equity value of all vehicles. Verification must be a written document providing reasonable evidence of value. Acceptable verification includes, but is not limited to, the following:

(i) the wholesale value (for cars and trucks) and finance value (for recreational vehicles) tables in the most recent vehicle valuation book that is used by the Division;

(ii) the low value in an older car valuation book (for cars and trucks). If the car or truck is too old to be listed in an older car valuation book, the Division will assign a value of $250;

(iii) the written appraisal of a licensed automobile dealer who deals with classic, custom-made, or antique vehicles, if the vehicle is considered a classic, custom-made, or antique; or

(iv) for recreational vehicles, the projected loan value as quoted by a bank or other lending institution; documents showing the value of the vehicle for insurance purposes; or a written estimate of the cash value of the vehicle from a licensed recreational vehicle dealer.

(g) Specially Equipped Vehicles. Special equipment for the handicapped, other optional equipment, or low mileage do not increase the value of the vehicle.

(G) Real Estate Other than the Principal Place of Residence.

(1) Real Estate as a Countable Asset. All real estate owned by the individual and the spouse, with the exception of the principal place of residence as described in 130 CMR 520.008(A), is a countable asset. Business or nonbusiness property as described in 130 CMR 520.008(D) is a noncountable asset.

(2) Nine-Month Exemption. The value of such real estate is exempt for nine calendar months after the date of notice by the Division, provided that the individual signs an agreement with the Division within 30 days after the date of notice to dispose of the property at fair-market value. The Division will extend the nine-month period as long as the individual or the spouse continues to make a good-faith effort to sell, as verified in accordance with 130 CMR 520.007(G)(4).

(3) Fair-Market Value and Equity Value. The fair-market value and equity value of all countable real estate owned by the individual and the spouse must be verified at the time of application and when it affects or may affect eligibility.

(a) The applicant or member must verify the fair-market value by a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction, provided that this assessment is not one of the following:

(i) a special purpose assessment;

(ii) based on a fixed-rate-per-acre method; or

(iii) based on an assessment ration or providing only a range.

(b) In the event that a current property-tax assessment is not available or the applicant or member wishes to rebut the fair-market value determined by the Division, a comparable market analysis or a written appraisal of the value of the property from a knowledgeable source will establish the fair-market value. A knowledgeable source is a licensed real-estate agent or broker, a real-estate appraiser, an official of a bank, a savings-and-loan association, or a similar lending organization, or an official of the local real-estate tax jurisdiction.

(c) A copy of the loan instruments or other binding documents that show evidence of the payment schedule and the outstanding balance of the loan will verify the equity value of the property.

(4) Good-Faith Effort to Sell Real Estate. The individual or the spouse must verify his or her good-faith effort to dispose of countable real estate by evidence such as advertisements or documentation of the listing of the real estate with licensed real-estate agents or brokers, including a report of any offer from prospective buyers. The Division will terminate eligibility if, at any time, the individual rejects a reasonable offer to buy the real estate. An offer to buy real estate is considered reasonable if it is at least two-thirds of the fair-market value, unless the individual proves otherwise to the Division's satisfaction.

(5) Proceeds from the Sale of Real Estate. The proceeds from the sale of the real estate, after the payment of loans, liens, or other encumbrances, and expenses of sale such as taxes, fees, and advertising costs, are a countable asset in the month received and in subsequent months.

(6) Right to Recovery. If a member fails to report the acquisition of real estate within 10 days after taking title to the real estate and the equity value of the real estate, when added to all other countable assets, exceeds the MassHealth asset standard, the Division has the right to recover overpayment in accordance with 130 CMR 515.010 and to initiate any and all other legal remedies available.

(7) Former Home of a Community-Based Individual. If an applicant or member (or spouse, if any) moves out of his or her home for reasons other than institutionalization without the intent to return, the home, whether or not held in trust, becomes a countable asset because it is no longer used as the individual's principal place of residence. The former home is subject to the requirements described in 130 CMR 520.007(G)(2).

(8) Former Home of an Institutionalized Individual. If an applicant or member moves out of his or her home to enter a medical institution, the Division considers the former home a countable asset that is subject to 130 CMR 520.007(G)(2), provided all of the following conditions are met. If the former home of a nursing-facility resident as defined in 130 CMR 515.001 is placed in a trust, the Division will apply the trust rules in accordance with 130 CMR 520.021 through 520.024.

(a) The individual is institutionalized as defined in 130 CMR 515.001.

(b) None of the following relatives of the individual is living in the property:

(i) a spouse;

(ii) a child who is under age 21 or who is blind or permanently and totally disabled;

(iii) a sibling who has a legal interest in the home and who was living there for a period of at least one year immediately before the applicant's or member's admission to the medical institution;

(iv) a son or daughter who was living in the applicant's or member's home for a period of at least two years immediately before the date of the applicant's or member's admission to the medical institution, and who establishes to the satisfaction of the Division that he or she provided care to the applicant or member that permitted him or her to live in the home rather than in a medical institution; or

(v) a dependent relative. A dependent relative is any of the following who has any kind of medical, financial, or other dependency: a child, stepchild, or grandchild; a parent, stepparent, or grandparent; an aunt, uncle, niece, or nephew; a brother, sister, stepbrother, or stepsister; a half brother or half sister; a cousin; or an in-law.

(c) The applicant or member (and spouse, if any) moves out of his or her home without the intent to return.

(d) The applicant or member does not own long-term-care insurance with coverage that meets the requirements of 130 CMR 515.014 and the Division of Insurance regulations at 211 CMR 65.09(1)(e)(2).

(9) Verification of Dependency and Residence of Relative Living in the Former Home.

(a) Relationship. The institutionalized individual must verify his or her relationship to the relative living in the former home by birth certificates, marriage licenses, or any other documents necessary to establish the relationship.

(b) Dependency. The institutionalized individual must verify the relative's dependency on the institutionalized individual by a signed statement from the relative attesting to the existence and duration of the dependency. The Division may require additional evidence if the relative's claim of dependency is questionable or self-contradictory.

(c) Residence. The institutionalized individual must verify the relative's residence in his or her former home only if there is conflicting or contradictory evidence regarding the relative's residence.

(10) Option to Liquidate to Pay for Medical Care. Instead of selling the countable former home, the individual may liquidate its equity value to pay for his or her medical care. If the individual chooses this option, the home will be noncountable until the equity value is liquidated, but not longer than nine calendar months after the date of the Division's notice.

(11) Undue Hardship: Jointly Owned Assets.

(a) The Division will continue to exclude otherwise countable property, including a former home, when it is jointly owned and the sale of the property by an individual would cause the other owners to lose housing.

(b) Loss of housing would result when the property serves as the principal place of residence for one (or more) of the other owners, and sale of the property would result in loss of that residence, and no other housing would be readily available for the displaced other owner. If undue hardship as defined in 130 CMR 520.007(G)(11) ceases to exist, the property becomes a countable asset.

(12) Lien. The Division will place a lien before the death of a member against any real estate in which the member has a legal interest. This lien will be placed only if all of the conditions of 130 CMR 515.012 are met.

(H) Retroactive SSI and RSDI Benefit Payments.

(1) Requirements. Retroactive SSI and RSDI benefit payments are noncountable in the month of receipt and for six months after the month of receipt. Such payments must be readily identifiable as retroactive SSI or RSDI payments, and should be deposited in a separately identifiable account. If commingled with other funds, and not separately identifiable according to the Division, the Division considers the total amount on deposit a countable asset. Any amount of the benefit payment still retained on the first day following the excluded periods described in 130 CMR 520.007(H)(1) is a countable asset.

(2) Verification. The applicant or member must verify the amount of the benefit and the date of receipt. The preferred source of verification is the notification letter from the Social Security Administration. The amount on deposit may be verified by a bank book or bank statement that shows that the benefit payment is not commingled with other funds.

(I) Trusts. The Division will count the value of the principal and income of a revocable or irrevocable trust in accordance with 130 CMR 520.021 through 520.024.

520.008: Noncountable Assets

Noncountable assets are those assets exempt from consideration when determining the value of assets. In addition to the noncountable assets described in 130 CMR 520.006 and 520.007, the following assets are noncountable.

(A) The Home. The home of the applicant or member and the spouse and any land appertaining to the home, as determined by the Division, if located in Massachusetts and used as the principal place of residence, are considered noncountable assets. The home is subject to the lien rules at 130 CMR 515.012. If the home is placed in a trust or in an arrangement similar to a trust, the Division will apply the trust rules at 130 CMR 520.021 through 520.024.

(B) Assets of an SSI Recipient.

(C) Proceeds from the Sale of a Home. The proceeds from the sale of a home used by the applicant or member as the principal place of residence, provided the proceeds are used to purchase another home to be used as the principal place of residence, are considered noncountable assets. Such proceeds are exempt from consideration as countable assets for the three calendar months following the month of receipt. The Division will place a lien before the death of the member against any real estate in which the member has a legal interest in accordance with 130 CMR 515.012.

(D) Business and Nonbusiness Property. Business and nonbusiness property essential to self-support and property excluded under an SSA-approved plan for self-support are considered noncountable assets.

(E) Any Loan or Grant. Any loan or grant including, but not limited to, scholarships, the terms of which preclude their use for current maintenance, is considered a noncountable asset.

(F) Funeral or Burial Arrangements.

(1) The following funeral or burial arrangements for the applicant, member, or spouse are considered noncountable assets:

(a) any burial space, including any burial space for any immediate family member;

(b) one of the following:

(i) a separately identifiable amount not to exceed $1,500 expressly reserved for funeral and burial expenses; or

(ii) life-insurance policies designated exclusively for funeral and burial expenses with a total face value not to exceed $1,500;

(c) the cash-surrender value of burial insurance; and

(d) prepaid irrevocable burial contracts or irrevocable trust accounts designated for funeral and burial expense.

(2) Appreciated value or interest earned or accrued and left to accumulate on any contracts, accounts, or life insurance is also noncountable. If the applicant, member, or spouse uses any of these assets, including the interest accrued, for other than funeral or burial arrangements of the applicant, member, or spouse, the Division considers the asset available and countable under the provisions of 130 CMR 520.007, 520.018, and 520.019.

(3) The applicant, member, or spouse has the right to establish a burial arrangement or change the designation of his or her funds to a burial arrangement described in 130 CMR 520.008(F). If such arrangement is made within 60 days after the date that the applicant or member was notified of his or her right to do so, then the Division considers the arrangement to have been in existence on the first day of the third month before the application.

(G) Veterans' Payments. Veterans' payments for aid and attendance, unreimbursed medical expenses, housebound benefits, and enhanced benefits retained after the month of receipt, provided these payments are separately identifiable, are considered noncountable assets. Appreciated value and earned interest are also noncountable.

(H) Special-Needs Trust. A special-needs trust in accordance with the trust rules at 130 CMR 520.021 through 520.024 is considered a noncountable asset.

(I) Pooled Trust. A pooled trust in accordance with the trust rules at 130 CMR 520.021 through 520.024 is considered a noncountable asset.

(J) ICF/MR Trust. A trust established before April 7, 1986, solely for the benefit of a resident of an intermediate-care facility for the mentally retarded (ICF/MR) is considered a noncountable asset.

(K) Other Assets. Any other assets considered noncountable for Title XIX eligibility purposes is considered a noncountable asset.

520.009: Countable-Income Amount

(A) Overview.

(1) An individual's and the spouse's gross earned and unearned income less certain business expenses and standard income deductions is referred to as the countable-income amount. In determining gross monthly income, the Division multiplies the average weekly income by 4.333 unless the income is monthly.

(2) For community residents, the countable-income amount is compared to the applicable income standard to determine the individual's financial eligibility.

(3) For institutionalized individuals, specific deductions described in 130 CMR 520.026 are applied against the individual's countable-income amount to determine the patient-paid amount.

(4) The types of income that are considered in the determination of eligibility are described in 130 CMR 520.009, 520.018, 520.019, and 520.021 through 520.024. These include income to which the applicant, member, or spouse would be entitled whether or not actually received when failure to receive such income results from the action or inaction of the applicant, member, spouse, or person acting on his or her behalf. In determining whether or not failure to receive such income is reasonably considered to result from such action or inaction, the Division will consider the specific circumstances involved.

(B) MassHealth Income Standards. Generally, financial eligibility is based on a percentage of the federal poverty level. The monthly federal-poverty-level standards are determined according to annual standards published in the *Federal Register*. The Division adjusts these standards in April of each year using the following formula:

(1) divide the annual federal-poverty-level income standard as it appears in the *Federal Register* by 12;

(2) multiply the unrounded monthly income standard by the applicable federal-poverty-level percentage; and

(3) round up to the next whole dollar to arrive at the monthly-income standards.

(C) Types of Earned Income. Earned income is the total amount of compensation received for work or services performed. Earned income includes wages, self-employment income, and payment from roomers and boarders.

(1) Self-employment Income. Gross income for the self-employed is the total amount of income listed on the most recent tax return before adjustments to income are made. A real-estate dealer, if engaged in the business of selling real estate to customers for profit, is considered to have self-employment earned income. Income from property that is owned by an individual who is not a real-estate dealer or is owned by the individual's spouse is considered unearned income.

(2) Income from Roomers and Boarders. Payment for room and meals received from anyone other than the spouse of the applicant or member is countable earned income. Gross income from roomers and boarders is the amount received for the room and board, less business expenses as described at 130 CMR 520.010(B).

(3) Verification of Earned Income. The applicant or member must verify gross earned income. However, if he or she is applying solely for MassHealth Buy-In, as described at 130 CMR 519.011(B), verification is required only upon Division request. Verifications include:

(a) two recent pay stubs;

(b) a signed statement from the employer;

(c) the most recent U.S. tax return or self-employment income records;

(d) for room and board: a statement signed by both parties stating the amount and frequency of payments; or

(e) other reliable evidence.

(D) Unearned Income. Income that does not directly result from an individual's own labor or services is unearned. Unearned income includes, but is not limited to, social security benefits, railroad retirement benefits, pensions, annuities, federal veterans' benefits, rental income, interest, and dividend income. Gross rental income is the countable rental-income amount received less business expenses as described at 130 CMR 520.010(C). The applicant or member must verify gross unearned income. However, if he or she is applying solely for MassHealth Buy-In, as described at 130 CMR 519.011(B), verification is required only upon Division request. Verifications include:

(1) a recent check stub showing gross income;

(2) a statement from the income source when matching is not available;

(3) for rental income: a written statement from the tenant or a copy of the lease; or

(4) other reliable evidence.

(E) Lump-Sum Payments. A lump-sum payment is a one-time-only payment that represents either windfall payments such as inheritances or legacies, or the accumulation of recurring countable income such as retroactive unemployment compensation or federal veterans' retirement benefits. Generally, lump-sum payments are counted as unearned income in the calendar month received and as an asset in subsequent months, except as provided in 130 CMR 520.009(E)(1).

(1) Exceptions. The following lump-sum payments are noncountable:

(a) a retroactive RSDI and/or SSI benefit payment, subject to the provisions of 130 CMR 520.007(H)(1);

(b) proceeds reserved for the replacement or repair of an asset that is lost, damaged, or stolen and any interest earned on such proceeds are exempt from consideration as assets for nine calendar months after the month of receipt and may be exempt for an additional nine calendar months where good cause exists;

(c) proceeds from the sale of a home used as the principal place of residence provided the proceeds are used to purchase another home to be used as the principal place of residence. Such proceeds are exempt from considerations as assets for three calendar months after the month of receipt;

(d) proceeds from the sale of real estate other than a home subject to the provisions of 130 CMR 520.007(G); and

(e) proceeds from the sale of nonexempt vehicles subject to the provisions of 130 CMR 520.007(F).

(2) Verifications. The applicant or member must verify a lump-sum payment. However, if he or she is applying solely for MassHealth Buy-In, as described at 130 CMR 519.011(B), verification is required only at Division request. Verifications include:

(a) a benefit or settlement award letter;

(b) a retirement-fund document indicating the amount of the lump-sum payment;

(c) a written statement from the agency, company, or institution making the payment;

(d) a copy of the payment document; or

(e) other reliable evidence.

520.010: Business Expenses

(A) Self-employment. Allowable business expenses from self-employment are those listed on Schedule C of the U.S. Tax Return form.

(B) Room and Board. For the rental of a room only, the Division allows 25 percent of the income to be deducted as business expenses. For income from both room and meals, the Division allows 75 percent of the income to be deducted as business expenses. The Division allows actual expenses only if the provider can document that they exceed these standard deductions.

(C) Rental Income.

(1) Allowable business expenses from rental income include carrying charges, cost of fuel and utilities provided to tenants, and any maintenance and repair costs.

(2) If the individual occupies an apartment in the same building from which he or she receives rental income, carrying charges are prorated per unit. The cost of fuel and utilities are prorated if they are paid through a single heating unit or meter.

(3) The Division may deduct actual maintenance and repair costs, other than cosmetic changes, from the amount of rental income if the individual verifies such expenses.

520.011: Standard Income Deductions

For community and institutionalized individuals, the Division allows certain standard earned- and unearned-income deductions from gross income. These deductions are described in 130 CMR 520.012 through 520.014.

520.012: Community Earned-Income Deductions

In addition to business expenses described at 130 CMR 520.010(A) and (B), MassHealth allows the following deductions from the gross earned income of each employed individual or married couple living in the community. These deductions do not apply to the income of a community spouse, as described at 130 CMR 520.026(B). Standard earned-income deductions are applied in the following order:

(A) $20, if there is no unearned income or, if there is unearned income that is less than $20, the balance of the $20 is disregarded from earned income;

(B) the next $65 a month of earned income; and

(C) one-half of the remaining earned income.

520.013: Community Unearned-Income Deductions

In addition to business expenses described at 130 CMR 520.010, MassHealth allows the deductions listed below from the total gross unearned income. These deductions do not apply to the income of a community spouse described at 130 CMR 520.026(B). The deductions allowed from the total gross unearned income are the following:

(A) a deduction of $20 per individual or married couple; or

(B) in determining eligibility for MassHealth Standard, a deduction that is equivalent to the difference between the applicable MassHealth deductible-income standard at 130 CMR 520.030 and 133 percent of the federal poverty level. This deduction includes, and is not in addition to, the $20 disregard.

(1) This deduction from gross unearned income is allowed only for persons who:

(a) are aged 65 and older;

(b) are receiving personal-care attendant services paid for by MassHealth, or have been determined by MassHealth, through initial screening or by prior authorization, to be in need of personal-care attendant services; and

(c) prior to applying the deduction at 130 CMR 520.013(B), have countable income that is over 100 percent of the federal poverty level.

(2) MassHealth will redetermine eligibility without this deduction if:

(a) after 90 days from the date of the MassHealth eligibility approval notice, the person is not receiving personal-care attendant services paid for by MassHealth or has not submitted, upon request from MassHealth, proof of efforts to obtain personal-care attendant services paid for by MassHealth; or

(b) MassHealth denies the prior-authorization request for personal-care attendant services.

(3) If countable income, prior to applying the deduction at 130 CMR 520.013(B), is greater than 133 percent of the federal poverty level, eligibility is determined under 130 CMR 519.005(B).

520.014: Long-Term-Care Earned-Income Deductions

(A) The following expenses may be deducted from the earnings of a long-term-care-facility resident:

(1) a standard deduction of $11; and

(2) any of the following work-related expenses deducted from salary:

(a) social security taxes (FICA);

(b) federal and state income taxes;

(c) retirement and employee benefit plans;

(d) health or medical insurance premiums; and

(e) union dues.

(B) Deductions that may be used to determine the amount owed to the long-term-care facility (patient-paid amount) are described at 130 CMR 520.026.

520.015: Noncountable Income

The following types of income are not considered in determining the financial eligibility of the applicant or member:

(A) the income of any individual who is a recipient of EAEDC or SSI;

(B) the portion of the income that is disregarded:

(1) for disabled adult children according to 130 CMR 519.004; and

(2) under the Pickle Amendment according to 130 CMR 519.003;

(C) income-in-kind;

(D) money received from a loan secured by the equity in the home of an individual who is aged 60 or older (reverse mortgage);

(E) veterans' aid and attendance benefits, unreimbursed medical expenses, housebound benefits, and enhanced benefits ($90 Veterans' Administration pension to long-term-care-facility residents, including veterans and their childless surviving spouses who live in a state veterans' home);

(F) social security cost-of-living adjustments until the subsequent federal-poverty-level adjustment for members who are community residents;

(G) retroactive RSDI and SSI benefit payments; and

(H) any other income considered noncountable under Title XIX.

520.016: Long-Term Care: Treatment of Assets

130 CMR 520.016 describes the treatment of countable assets when one member of a couple is institutionalized, the post-eligibility transfer of assets, and the allowable income deductions for applicants and members who are residents of a long-term-care facility.

(A) Institutionalized Individuals. The total value of assets owned by an institutionalized single individual or by a member of an institutionalized couple must not exceed $2,000.

(B) Treatment of a Married Couple's Assets When One Spouse Is Institutionalized.

(1) Assessment.

(a) Requirement. The Division completes an assessment of the total value of a couple's combined countable assets and computes the spousal share as of the date of the beginning of the most recent continuous period of institutionalization of one spouse.

(b) Right to Request an Assessment. When one spouse has entered a medical institution and is expected to remain institutionalized for at least 30 days, either spouse may request the Division to make this assessment, even if the institutionalized spouse is not applying for MassHealth Standard at that time. The period of institutionalization must be continuous and expected to last for at least 30 days.

(c) Right to Appeal. The Division must give each spouse a copy of the assessment and the documentation used to make such assessment. Each spouse must be notified that he or she has the right to appeal the determination of countable assets and the community spouse's asset allowance when the institutionalized spouse (or eligibility representative) applies for MassHealth Standard.

(2) Determination of Eligibility for the Institutionalized Spouse. At the time that the institutionalized spouse applies for MassHealth Standard, the Division must determine the couple's current total countable assets, regardless of the form of ownership, and the amount of assets allowed for the community spouse as follows.

(a) Deduct the community spouse's asset allowance from the current combined total countable assets. The community spouse's asset allowance is not considered available to the institutionalized spouse when determining the institutionalized spouse's eligibility for MassHealth Standard. The community spouse's asset allowance is the greatest of the following amounts:

(i) one-half of the combined total countable assets of the institutionalized spouse and the community spouse, not to exceed $92,760;

(ii) $18,552, if the total combined countable assets of the couple are between $18,552 and $37,104;

(iii) the amount of the couple's total countable assets, if the total combined amount is $18,552 or less;

(iv) a court-ordered amount; or

(v) an amount determined after a fair hearing in accordance with 130 CMR 520.017.

(b) Compare the amount of the remaining assets to the MassHealth asset standard for one person, which is $2,000. When the amount of the remaining assets is equal to or below $2,000, the institutionalized spouse has met the asset test of eligibility.

(3) Post-Eligibility Transfer of Assets.

(a) To meet the needs of the community spouse and to allow the continuing eligibility of the institutionalized spouse, the Division allows the institutionalized spouse, after he or she has been determined eligible for MassHealth Standard, to transfer assets to or for the sole benefit of the community spouse in accordance with 130 CMR 520.016(B)(1) and (2).

(b) The institutionalized spouse must transfer any of his or her assets that are part of the community spouse's asset allowance no later than 90 days immediately after the date of the notice of approval for MassHealth Standard. During this 90-day period, the Division:

(i) will continue to exclude these assets in the determination of continuing eligibility; and

(ii) will not apply the transfer rules in 130 CMR 520.018 and 520.019 to the assets transferred to the community spouse.

(c) The Division may extend the 90-day period if any of the following conditions exist:

(i) the court is involved in assigning the couple's property through support actions;

(ii) an appeal of the asset allowance has been filed with the Board of Hearings; or

(iii) the condition of the institutionalized spouse requires the appointment of a conservator or guardian to act on his or her behalf.

(d) The amount of the transferred assets added to the assets owned by the community spouse cannot exceed the community spouse's asset allowance as defined in 130 CMR 520.016(B)(2).

(e) After the initial 90-day period or the extension is over, the Division will count all assets that remain in the institutionalized spouse's name in determining his or her eligibility.

(4) Retroactive Eligibility. In determining the eligibility of the institutionalized spouse for the three-month retroactive period before application in a continuous period of institutionalization, the Division deducts the amount defined in 130 CMR 520.016(B)(2) from the couple's total countable assets.

(5) Eligibility of the Community Spouse. The amount defined in 130 CMR 520.016(B)(2) must be counted in determining the community spouse's eligibility for MassHealth.

520.017: Right to Appeal the Asset Allowance or Minimum-Monthly-Maintenance-Needs Allowance

(A) Request for an Adjustment to the Community Spouse's Asset Allowance. After the institutionalized spouse has applied for MassHealth Standard and has received a notice of approval or denial for MassHealth Standard, either spouse may appeal to the Board of Hearings to request an adjustment to the asset allowance. The purpose of the adjustment is to generate sufficient income, as determined by the Division, for the community spouse to remain in the community.

(B) Minimum-Monthly-Maintenance-Needs Allowance. The minimum-monthly-maintenance-needs allowance is the amount needed by the community spouse to remain in the community. This amount is based on a calculation that includes the community spouse's shelter and utility costs in addition to certain federal standards, in accordance with 130 CMR 520.026(B)(1).

(C) Adjustment of the Amount of Asset Allowance. If either spouse claims at a fair hearing that the amount of income generated by the community spouse's asset allowance as determined by the Division is inadequate to raise the community spouse's income to the minimum-monthly-maintenance-needs allowance, the fair-hearing officer will determine the gross income available to the community spouse as follows.

(1) The fair-hearing officer will determine the gross amount of income available to the community spouse. The fair-hearing officer will include the amount of the income that would be generated by the spouse's asset allowance if the asset allowance were invested in an account and generating income equal to the highest rate quoted in the Bank Rate Monitor Index as of the hearing date.

(2) If the community spouse's gross income under 130 CMR 520.017(C)(1) is less than the minimum-monthly-maintenance-needs allowance (MMMNA), then the fair-hearing officer will allow an amount of income from the institutionalized spouse (after the personal-needs deduction described in 130 CMR 520.026(A)) that would increase the community spouse's total income to equal, but not to exceed, the MMMNA. 130 CMR 520.017(C)(2) will apply to all hearings held on or after September 1, 2003, regardless of the date of application.

(3) If after the fair-hearing officer has increased the community spouse's gross income under 130 CMR 520.017(C)(1) and (2), the community spouse's gross income is still less than the MMMNA, then the fair-hearing officer will increase the community spouse's asset allowance by the amount of additional assets that, if invested at the highest rate quoted in the Bank Rate Monitor Index as of the hearing date, would generate sufficient income to raise the income total to the MMMNA.

(D) Adjustment to the Minimum-Monthly-Maintenance-Needs Allowance Due to Exceptional Circumstances. After the institutionalized spouse has received notice of either approval or denial for MassHealth Standard, either spouse may appeal to the Board of Hearings the calculation of income available to the community spouse and request an increase in the MMMNA, based on exceptional circumstances, as defined in 130 CMR 520.017(D)(1).

(1) Exceptional Circumstances. Exceptional circumstances exist when there are circumstances other than those already taken into account in establishing the maintenance standards for the community spouse under 130 CMR 520.026(B) and these circumstances result in significant financial duress. Since the federal standards used in calculating the MMMNA cover such necessities as food, shelter, clothing, and utilities, exceptional circumstances are limited to those necessities that arise from the medical condition, frailty, or similar special needs of the community spouse. Such necessities include, but are not limited to, special remedial and support services and extraordinary uncovered medical expenses. Such expenses generally do not include car payments, even if the car is used for transportation to medical appointments, or home-maintenance expenses such as security systems and lawn care.

(a) In determining an increased MMMNA, the fair-hearing officer will ensure that no expense (for example, for food or utilities) is counted more than once in the calculation.

(b) If the community spouse lives in an assisted-living facility or similar facility and requests an increase in his or her minimum-monthly-maintenance-needs allowance, the fair-hearing officer will review the housing agreement, service plan, fee schedule, and other pertinent documents to determine whether exceptional circumstances exist. Additional amounts will be allowed only for specific expenses necessitated by exceptional circumstances of the community spouse and not for maintaining any pre-set standard of living.

(2) Determination of Increase for Exceptional Circumstances. If the fair-hearing officer determines that exceptional circumstances exist, the fair-hearing officer may increase the community spouse's MMMNA to meet the expenses caused by the exceptional circumstances as follows.

(a) The fair-hearing officer will first verify that the calculation of the gross income of the community spouse in determining the existing spousal-maintenance-needs deduction includes the income generated by the community spouse's asset allowance. If the community spouse has no assets remaining from the allowance, he or she must verify the dollar amount of the remaining assets, if any, and how the money was spent. The fair-hearing officer will consider how the assets were spent in determining whether or not significant financial duress exists.

(b) The fair-hearing officer will determine the revised MMMNA by including in the calculation the amount needed to meet the exceptional circumstances.

(c) The fair-hearing officer will compare the revised MMMNA to the community spouse's total income. If the community spouse's total income is less than the amount of the revised MMMNA, the fair-hearing officer will first deduct the personal-needs allowance from the institutionalized spouse's countable-income amount and then a spousal-maintenance-needs deduction needed to reach the revised MMMNA.

520.018: Transfer of Resources Regardless of Date of Transfer

(A) The provisions of 42 U.S.C. 1396p apply to all transfers of resources. In the event that any portion of 130 CMR 520.018 and 520.019 conflicts with federal law, the federal law supersedes.

(B) The Division will deny payment for nursing-facility services to an otherwise eligible nursing-facility resident as defined in 130 CMR 515.001 who transfers or whose spouse transfers countable resources for less than fair-market value during or after the period of time referred to as the look-back period.

(C) The denial of payment for nursing-facility services does not affect the individual's eligibility for other MassHealth benefits.

520.019: Transfer of Resources Occurring on or after August 11, 1993

(A) Payment of Nursing-Facility Services. The Division will apply the provisions of 130 CMR 520.018 and 520.019 to nursing-facility residents as defined at 130 CMR 515.001 requesting MassHealth payment for nursing-facility services provided in a nursing facility or in any institution for a level of care equivalent to that received in a nursing facility or for home- and community-based services provided in accordance with 130 CMR 519.007(B).

(B) Look-Back Period. Transfers of resources are subject to a look-back period, beginning on the first date the individual is both a nursing-facility resident and has applied for or is receiving MassHealth Standard. This period generally extends back in time for 36 months. The look-back period for transfers of resources from a revocable trust to someone other than the nursing-facility resident, or transfers of resources into an irrevocable trust where future payment to the nursing-facility resident is prevented, is 60 months.

(C) Disqualifying Transfer of Resources. The Division considers any transfer during the appropriate look-back period by the nursing-facility resident or spouse of a resource, or interest in a resource, owned by or available to the nursing-facility resident or the spouse (including the home or former home of the nursing-facility resident or the spouse) for less than fair-market value a disqualifying transfer unless listed as permissible in 130 CMR 520.019(D), identified in 130 CMR 520.019(F), or exempted in 130 CMR 520.019(J). The Division may consider as a disqualifying transfer any action taken to avoid receiving a resource to which the nursing-facility resident or spouse is or would be entitled if such action had not been taken. Action taken to avoid receiving a resource may include, but is not limited to, waiving the right to receive a resource, not accepting a resource, agreeing to the diversion of a resource, or failure to take legal action to obtain a resource. In determining whether or not failure to take legal action to receive a resource is reasonably considered a transfer by the individual, the Division will consider the specific circumstances involved. A disqualifying transfer may include any action taken which would result in making a formerly available asset no longer available.

(D) Permissible Transfers. The Division considers the following transfers permissible. Transfers of resources made "for the sole benefit of" a particular person must be in accordance with federal law.

(1) The resources were transferred to the spouse of the nursing-facility resident or to another for the sole benefit of the spouse. A nursing-facility resident who has been determined eligible for MassHealth payment of nursing-facility services and who has received an asset assessment from the Division must make any necessary transfers within 90 days after the date of the notice of approval for MassHealth in accordance with 130 CMR 520.016(B)(3).

(2) The resources were transferred from the spouse of the nursing-facility resident to another for the sole benefit of the spouse.

(3) The resources were transferred to the nursing-facility resident's permanently and totally disabled or blind child or to a trust, a pooled trust, or a special-needs trust created for the sole benefit of such child.

(4) The resources were transferred to a trust, a special-needs trust, or a pooled trust created for the sole benefit of a permanently and totally disabled person who was under 65 years of age at the time the trust was created or funded.

(5) The resources were transferred to a pooled trust created for the sole benefit of the permanently and totally disabled nursing-facility resident.

(6) The nursing-facility resident transferred the home he or she used as the principal residence at the time of transfer and the title to the home to one of the following persons:

(a) the spouse;

(b) the nursing-facility resident's child who is under age 21, or who is blind or permanently and totally disabled;

(c) the nursing-facility resident's sibling who has a legal interest in the nursing-facility resident's home and was living in the nursing-facility resident's home for at least one year immediately before the date of the nursing-facility resident's admission to the nursing facility; or

(d) the nursing-facility resident's child (other than the child described in 130 CMR 520.019(D)(6)(b)) who was living in the nursing-facility resident's home for at least two years immediately before the date of the nursing-facility resident's admission to the institution, and who, as determined by the Division, provided care to the nursing-facility resident that permitted him or her to live at home rather than in a nursing facility.

(7) The resources were transferred to a separately identifiable burial account, burial arrangement, or a similar device for the nursing-facility resident or the spouse in accordance with 130 CMR 520.008(F).

(E) Repayment of Financial and Medical Assistance. A nursing-facility resident who has received or will be receiving payment from a third party as a result of an accident, injury, or other loss must first repay the Division for medical assistance under M.G.L. c. 118E, § 22 and 42 U.S.C. 1396a(a)(25)(A) and (B) and the Department of Transitional Assistance for financial assistance under M.G.L. c. 18, § 5G, before the Division will consider whether a transfer of such third-party payments may be permissible under 130 CMR 520.019(D), (F), or (J).

(F) Determination of Intent. In addition to the permissible transfers described in 130 CMR 520.019(D), the Division will not impose a period of ineligibility for transferring resources at less than fair-market value if the nursing-facility resident or the spouse demonstrates to the Division's satisfaction that:

(1) the resources were transferred exclusively for a purpose other than to qualify for MassHealth; or

(2) the nursing-facility resident or spouse intended to dispose of the resource at either fair-market value or for other valuable consideration. Valuable consideration is a tangible benefit equal to at least the fair-market value of the transferred resource.

(G) Period of Ineligibility Due to a Disqualifying Transfer.

(1) Duration of Ineligibility. Where the Division has determined that a disqualifying transfer of resources has occurred, the Division will calculate a period of ineligibility. The number of months in the period of ineligibility is equal to the total, cumulative, uncompensated value as defined in 130 CMR 515.001 of all resources transferred by the nursing-facility resident or the spouse, divided by the average monthly cost to a private patient receiving nursing-facility services in the Commonwealth of Massachusetts at the time of application, as determined by the Division.

(2) Determination of the Period of Ineligibility in Special Circumstances. The Division will determine the periods of ineligibility in the following situations.

(a) Transfers in the Same Month. When a number of resources have been transferred in the same month, the Division will calculate the period of ineligibility by dividing the total value of the transferred resources by the average monthly cost to a private patient receiving nursing-facility services in the Commonwealth of Massachusetts at the time of application, as determined by the Division. The period of ineligibility will begin on the first day of the month in which the resources were transferred.

(b) Periods of Ineligibilty that Overlap. When transfers of resources result in periods of ineligibility that overlap, the Division will add the value of all the transferred resources and divide the total by the average monthly cost to a private patient receiving nursing-facility services in the Commonwealth of Massachusetts at the time of application, as determined by the Division. The result will be a single period of ineligibility beginning on the first day of the month in which the first transfer was made.

(c) Periods of Ineligibility that Do Not Overlap. In the case of multiple transfers where the periods of ineligibility for each transfer do not overlap, the Division will consider each transfer as a separate event with its own period of ineligibility.

(d) Periods of Ineligibility of Less Than One Month. Where the calculated period of ineligibility is less than one month, the Division will impose a partial-month period of ineligibility.

(e) Transfer of Lump-Sum Income. When income has been transferred as a lump sum, the Division will calculate the period of ineligibility on the lump-sum value.

(f) Transfer of Stream of Income. When a stream of income has been transferred, the Division will calculate the period of ineligibility for each income payment that is periodically transferred. The Division may impose partial-month periods of ineligibility.

(g) Transfer of the Right to a Stream of Income. When the right to a stream of income has been transferred, the Division will calculate the period of ineligibility based on the total amount of income expected to be transferred during the nursing-facility resident's life, according to the life-expectancy tables as determined by the Division.

(h) Transfer by the Spouse. When a transfer by the spouse results in a period of ineligibility for the nursing-facility resident, and the spouse later becomes institutionalized and applies for MassHealth payment of nursing-facility services, the Division will apportion the remaining period of ineligibility equally between the spouses. If both spouses become nursing-facility residents in the same month, the Division will divide the period of ineligibility equally between them. When one spouse is no longer subject to a penalty, any remaining penalty must then be imposed on the remaining nursing-facility-resident spouse.

(3) Begin Date. The period of ineligibility will begin on the first day of the month in which resources have been transferred for less than fair-market value. For transfers involving revocable trusts, the date of transfer is the date the payment to someone other than the nursing-facility resident or the spouse is made. For transfers involving irrevocable trusts, the date of transfer is:

(a) the date that the countable trust resources are transferred to someone other than the nursing-facility resident or spouse; or

(b) the latest of the following:

(i) the date that payment to the nursing-facility resident or the spouse was foreclosed under the terms of the trust;

(ii) the date that the trust was established; or

(iii) the date that any resource was placed in the trust.

(H) Transfers of Jointly Held Resources. The Division will determine the amount of the nursing-facility resident's ownership interest of jointly held resources as defined in 130 CMR 515.001 in accordance with the ownership rules at 130 CMR 520.005. The Division will consider as a transfer any action taken by any person that reduces or eliminates the nursing-facility resident's ownership or control of the resource. The Division then will determine whether the transfer was made at less than fair-market value in accordance with the transfer rules.

(I) Transfer of Life-Estate and Remainder Interest. The rules pertaining to transfer of life-estate and remainder interest apply in instances involving remainder interest of property including life estates, annuities, wills, and trusts.

(1) The Division considers a transfer of property with the retention of a life estate, as defined in 130 CMR 515.001, to be a transfer of resources. The difference between the fair-market value of the entire asset and the value of the life estate is called the remainder interest. The remainder interest is the amount considered to be transferred at less than fair-market value. The Division will calculate the values of the remainder interest and the life estate in accordance with the life-estate tables, as determined by the Division. If the language of the document creating the life estate explicitly states that the owner of the life estate has the power to sell the entire property (not simply the life estate), then the creation of this type of life estate will be treated as a trust.

(2) If the nursing-facility resident's or the spouse's life-estate interest or property including the life-estate interest is sold or transferred, the value of the life-estate interest at the time of the sale or transfer is calculated in accordance with the life-estate tables, as determined by the Division. The Division will attribute the value of the life-estate interest at the time of the sale or transfer to the person selling or transferring the life estate.

(J) Exempting Transfers from the Period of Ineligibility.

(1) During the Eligibility Process. To avoid the imposition of a period of ineligibility, the nursing-facility resident may take action during the determination of eligibility before the issuance of a notice of a period of ineligibility as follows.

(a) Revising a Trust. During the eligibility process, the nursing-facility resident may revise a trust to comply with the criteria of a special-needs trust or a pooled trust, as defined in 130 CMR 515.001. The use of resources to create these trusts are permissible transfers, in accordance with 130 CMR 520.019(D). The Division will use the original application date if during the eligibility process the nursing-facility resident provides proof that the trust has been revised accordingly.

(b) Curing a Transfer. During the eligibility process, the full value or a portion of the full value of the transferred resources may be returned to the nursing-facility resident. The Division will use the original application date and consider the transfer to have been eliminated or adjusted. The Division will apply the countable assets rules at 130 CMR 520.007 and the countable income rules at 130 CMR 520.009 to the returned resources in determining eligibility.

(2) After Issuance of the Notice of the Period of Ineligibility. After the issuance of the notice of the period of ineligibility, the nursing-facility resident may avoid imposition of the period of ineligibility in the following instances.

(a) Revising a Trust. If the nursing-facility resident revises a trust to comply with the criteria of a special-needs trust or a pooled trust as defined in 130 CMR 515.001 and exempted in 130 CMR 520.019(D), the Division will rescind the period of ineligibility as follows.

(i) The Division will use the original application date if within 60 days after the date of the notice of the period of ineligibility, the nursing-facility resident provides proof that the trust has been revised to comply with the criteria of a special-needs trust or a pooled trust. The Division may extend the original 60-day period for an additional 120 days, if court action is required to revise the trust, as long as the court action is filed within the 60-day period after the date of the notice of the period of ineligibility.

(ii) If after the 60th day after the date of the notice of the period of ineligibility, the nursing-facility resident provides proof that the trust has been revised to comply with the criteria of a special-needs trust or a pooled trust, the Division will consider the trust revised as of the date the trust has been both revised and notarized.

(b) Curing a Transfer. If the full value or a portion of the full value of the transferred resources is returned to the nursing-facility resident, the Division will rescind or adjust the period of ineligibility and will apply the countable-assets rules at 130 CMR 520.007 and the countable-income rules at 130 CMR 520.009 to the returned resources in the determination of eligibility. The Division will rescind or adjust the period of ineligibility as follows.

(i) The Division will use the original application date if the nursing-facility resident provides proof within 60 days after the date of the notice of the period of ineligibility that the transfer has been fully or partially cured. In the case of a partial cure, the Division will recalculate the period of ineligibility based on the transferred amount remaining after deducting the cured portion, beginning with the date of transfer.

(ii) If the nursing-facility resident provides proof later than the 60th day after the date of the notice of a period of ineligibility that the transfer has been fully or partially cured, the nursing-facility resident must reapply. The Division will recalculate the period of ineligibility based on the amount of the transfer remaining after the cure, beginning with the date of transfer.

(K) Waiver of the Period of Ineligibility due to Undue Hardship. In addition to revising a trust and curing a transfer, the nursing-facility resident may claim undue hardship in order to eliminate the period of ineligibility.

(1) The Division may waive a period of ineligibility due to a disqualifying transfer of resources if ineligibility would cause the nursing-facility resident undue hardship. The Division may waive the entire period of ineligibility or only a portion when all of the following circumstances exist.

(a) The denial of MassHealth would deprive the nursing-facility resident of medical care such that his or her health or life would be endangered, or the nursing-facility resident would be deprived of food, shelter, clothing, or other necessities such that he or she would be at risk of serious deprivation.

(b) All appropriate attempts to retrieve the transferred resource have been exhausted, and the recipient of the transfer is unable or unwilling to return the resource or to provide adequate compensation to the nursing-facility resident.

(c) The institution has notified the nursing-facility resident of its intent to initiate a discharge of the resident because the resident has not paid for his or her institutionalization.

(d) There is no less costly noninstitutional alternative available to meet the nursing-facility resident 's needs.

(2) Undue hardship does not exist when imposition of the period of ineligibility would merely inconvenience or restrict the nursing-facility resident without putting the nursing-facility resident at risk of serious deprivation.

(3) Where the Division has issued a notice of the period of ineligibility due to a disqualifying transfer of resources, the nursing-facility resident may request a hardship waiver.

(4) If the nursing-facility resident feels the imposition of a period of ineligibility would result in undue hardship, the nursing-facility resident must submit a written request for consideration of undue hardship and any supporting documentation to the MassHealth Enrollment Center listed on the notice of the period of ineligibility within 15 days after the date on the notice. Within 30 days after the date of the nursing-facility resident's request, the Division will inform the nursing-facility resident in writing of the undue-hardship decision and of the right to a fair hearing. The Division will extend this 30-day period if the Division requests additional documentation or if extenuating circumstances as determined by the Division require additional time.

(5) The nursing-facility resident may appeal the Division's undue-hardship decision and the imposition of a period of ineligibility by submitting a request for a fair hearing to the Division's Board of Hearings within 30 days after the nursing-facility resident's receipt of the Division's written undue-hardship notice, in accordance with 130 CMR 610.000.

(6) The nursing-facility resident's request for consideration of undue hardship does not limit his or her right to request a fair hearing for reasons other than undue hardship.

(L) Fraudulent Transfer or Sale. If a nursing-facility resident whose estate would be subject to a claim under 130 CMR 515.011 transfers or sells any property including a home or an interest in the property for less than fair-market value, the Division may consider the transfer or sale that does not meet the conditions of 130 CMR 520.019(D)(6) to be fraudulent under the Uniform Fraudulent Conveyance Act (M.G.L. c. 109(A)) and take appropriate legal action to set aside the transfer or sale.

(M) No Double Penalty. In the event that application of the transfer rules and the trust rules in 130 CMR 520.000 results in a nursing-facility resident being subject to a transfer penalty twice for actions involving the same resource, the trust rules will supersede the transfer rules in the determination of eligibility.

520.021: Treatment of Trusts

130 CMR 520.021 through 520.024 explains how to treat the principal of and payments from a revocable or irrevocable trust established by the individual or by the spouse. 130 CMR 520.024(A) also includes trusts established by other than the individual or spouse and trusts whether or not established by will. In the event that a portion of 130 CMR 520.021 through 520.024 conflicts with federal law, the federal law supersedes.

520.022: Trusts or Similar Legal Devices Created before August 11, 1993

(A) Revocable Trust. The assets and income of an individual or spouse in a revocable trust are countable. The fair-market value of the home or former home of the nursing-facility resident or spouse in a revocable trust is a countable asset. Where the home or former home is an asset of the trust, the home or former home is not subject to the exemptions of 130 CMR 520.007(G)(2) or 520.007(G)(8).

(B) Medicaid Qualifying Trust.

(1) A Medicaid qualifying trust is a revocable or irrevocable trust or similar legal device, created or funded by the individual or spouse, other than by a will, under which:

(a) the individual is a beneficiary of all or part of the discretionary or required payments or distributions from the trust; and

(b) a trustee or trustees are permitted to exercise any discretion to make payments or distributions to the individual.

(2) The maximum amount of payments or fair-market value of property that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the individual is countable in the determination of eligibility.

(3) The fair-market value of the home or former home of the nursing-facility resident in a Medicaid qualifying trust is a countable asset and is not subject to the exemptions described at 130 CMR 520.007(G)(2) or 520.007(G)(8).

(C) Certain Trusts Created before April 7, 1986. A trust created before April 7, 1986, solely for the benefit of a resident in an intermediate-care facility for the mentally retarded (ICF/MR) is not considered a Medicaid qualifying trust.

520.023: Trusts or Similar Legal Devices Created on or after August 11, 1993

The trust and transfer rules at 42 U.S.C. 1396p apply to trusts or similar legal devices created on or after August 11, 1993, that are created or funded other than by a will. Generally, resources held in a trust are considered available if under any circumstances described in the terms of the trust, any of the resources can be made available to the individual.

(A) Look-Back Period for Transfers into or from Trusts.

(1) 36-Month Look-Back Period. Where all or any portion of the income or principal of an irrevocable trust can be paid to or for the benefit of the nursing-facility resident, but is paid instead to someone else, the look-back period for the transfer to someone else is 36 months.

(2) 60-Month Look-Back Period. The look-back period is 60 months for the following trusts:

(a) where payments are made from a revocable trust to other than the nursing-facility resident and are not for the benefit of the nursing-facility resident; and

(b) where payments are made into an irrevocable trust where all or a portion of the trust principal or the income from the principal cannot under any circumstances be paid to or for the benefit of the nursing-facility resident.

(3) All payments or transfers in 130 CMR 520.023(A)(1) and (2) are considered transfers of resources for less than fair-market value and the transfer rules at 130 CMR 520.018 and 520.019 apply.

(4) The Division determines the amount of the transfer and the period of ineligibility for payment of nursing-facility services in accordance with the rules at 130 CMR 520.019(G).

(B) Revocable Trusts.

(1) The entire principal in a revocable trust is a countable asset.

(2) Payments from a revocable trust made to or for the benefit of the individual are countable income.

(3) Payments from a revocable trust made other than to or for the benefit of the nursing-facility resident are considered transfers for less than fair-market value and are treated in accordance with the transfer rules at 130 CMR 520.019(G).

(4) The home or former home of a nursing-facility resident or spouse held in a revocable trust is a countable asset. Where the home or former home is an asset of the trust, it is not subject to the exemptions of 130 CMR 520.007(G)(2) or 520.007(G)(8).

(C) Irrevocable Trusts.

(1) Portion Payable.

(a) Any portion of the principal or income from the principal (such as interest) of an irrevocable trust that could be paid under any circumstances to or for the benefit of the individual is a countable asset.

(b) Payments from the income or from the principal of an irrevocable trust made to or for the benefit of the individual are countable income.

(c) Payments from the income or from the principal of an irrevocable trust made to another and not to or for the benefit of the nursing-facility resident are considered transfers of resources for less than fair-market value and are treated in accordance with the transfer rules at 130 CMR 520.019(G).

(d) The home or former home of a nursing-facility resident or spouse held in an irrevocable trust that is available according to the terms of the trust is a countable asset. Where the home or former home is an asset of the trust, it is not subject to the exemptions of 130 CMR 520.007(G)(2) or 520.007(G)(8).

(2) Portion Not Payable. Any portion of the principal or income from the principal (such as interest) of an irrevocable trust that could not be paid under any circumstances to or for the benefit of the nursing-facility resident will be considered a transfer for less than fair-market value and treated in accordance with the transfer rules at 130 CMR 520.019(G).

(D) Exemptions to the Trust Rules.

(1) Special-Needs Trusts and Pooled Trusts. Under federal trust exemption regulations at 42 U.S.C. 1396(p)(d)(4) special-needs trusts and pooled trusts as defined in 130 CMR 515.001 are not subject to the income and asset countability rules at 130 CMR 520.023(B) and (C).

(2) Revision of a Trust to Comply with the Criteria of a Special-Needs or Pooled Trust. The Division will not deny or terminate MassHealth due to excess assets if a trust is revised to comply with the criteria of a special-needs trust or a pooled trust in accordance with the rules at 130 CMR 520.019(J).

(3) Burial Trust. A burial trust is a trust established to pay solely for various funeral and burial expenses of the individual or the spouse. An irrevocable burial trust meeting the criteria of 130 CMR 520.008(F) is not a countable asset.

520.024: General Trust Rules

130 CMR 520.024 applies to trusts whether or not established by will and whether or not established by the individual or spouse.

(A) Irrevocable Trust.

(1) The assets and income held in an irrevocable trust established by the individual or spouse that the trustee is required to distribute to or for the benefit of the individual are countable.

(2) Payments from the income or principal of an irrevocable trust established by the individual or spouse to or for the benefit of the individual are countable.

(3) The assets and income held in an irrevocable trust established by other than the individual or spouse that the trustee is required to distribute to the individual are countable.

(4) Payments from the income or the principal of an irrevocable trust established by other than the individual or spouse to the individual are countable.

(B) Home in Trust: Community-Based Individuals. For an applicant or member who is not a nursing-facility resident, the principal place of residence held in a revocable or irrevocable trust is a noncountable asset. A home that is not the principal place of residence is countable and not subject to the exemptions of 130 CMR 520.007(G)(2) while an asset of the trust.

(C) Home in Trust: Cure.

(1) If the Division has denied or terminated MassHealth because the home or former home in trust is considered an excess asset, the Division will rescind that action if the home or former home has been removed from the trust and returned to the nursing-facility resident in accordance with the full cure rules at 130 CMR 520.019(J).

(2) When the home or former home is removed from a trust, as determined by the Division, the Division will redetermine eligibility using the rules at 130 CMR 520.007(G)(8) and the full cure rules at 520.019(J).

(3) When the home or former home has been removed from the trust, the Division may place a lien in accordance with 130 CMR 515.012.

(D) Repayment of Financial and Medical Assistance. An individual who has received or will be receiving payments from a third party as a result of an accident, injury, or other loss must first repay the Division for medical assistance under M.G.L. c. 118E, § 22 and 42 U.S.C. 1396a(a)(25)(A) and (B) and the Department of Transitional Assistance for financial assistance under M.G.L c. 18, § 5G, even if such third-party payments have been or will be placed in a special-needs or pooled trust in accordance with 42 U.S.C. 1396p(d)(4).

(E) Waiver of the Trust Rules: Undue Hardship. When the Division denies or terminates MassHealth due to excess assets, the individual may request, in accordance with 130 CMR 520.019(K), that the Division rescind the denial or termination because such action would result in undue hardship.

(F) Verification of a Trust. The individual must provide the Division with a copy of the trust or similar legal device or, when appropriate, a will and any information detailing investments, holdings, and distributions, as determined by the Division.

(G) No Double Penalty. The Division will apply the rules at 130 CMR 520.019(M) to prevent double penalty.

520.025: Long-Term-Care Income Standard

The MassHealth income standard for long-term-care residents is $60 per month.

520.026: Long-Term-Care General Income Deductions

General income deductions must be taken in the following order: a personal-needs allowance; a spousal-maintenance-needs allowance; a family-maintenance-needs allowance for qualified family members; a home-maintenance allowance; and health-care coverage and incurred medical and remedial-care expenses. These deductions are used in determining the monthly patient-paid amount.

(A) Personal-Needs Allowance.

(1) The Division deducts $60 for a long-term-care resident's personal-needs allowance (PNA).

(2) If an individual does not have income totaling the standard, the Division will pay the individual an amount up to that standard on a monthly basis.

(3) The PNA for SSI recipients is $65.

(B) Spousal-Maintenance-Needs-Deduction. If the community spouse’s gross income is less than the amount he or she needs to live in the community (minimum-monthly-maintenance-needs allowance, MMMNA) as determined by the Division, the Division may deduct an amount from the institutionalized spouse’s countable-income amount to meet this need. This amount is the spousal-maintenance-needs deduction. 130 CMR 520.026(B) applies to the first month of eligibility in an institution and terminates the first full calendar month in which the spouse is no longer in an institution or no longer has a spouse in the community. This deduction is the amount by which the minimum-monthly-maintenance-needs allowance exceeds the community spouse's gross income.

(1) MassHealth determines the MMMNA by adding the following amounts:

(a) $1,562 (the federal standard maintenance allowance); and

(b) an excess shelter allowance determined by calculating the difference between the standard shelter expense of $469 and the shelter expenses for the community spouse's principal residence, including:

(i) the actual expenses for rent, mortgage (including interest and principal), property taxes and insurance, and any required maintenance charge for a condominium or cooperative; and

(ii) the applicable standard deduction under the Food Stamp Program for utility expenses. If heat is included in the rent or condominium fee, this amount is $258. If heat is not included in the rent or condominium fee, this amount is $425.

(2) The maximum-monthly-maintenance-needs allowance is $2,319 per month, unless it has been increased as the result of a fair-hearing decision based on exceptional circumstances in accordance with 130 CMR 520.017(D).

(3) If the institutionalized individual is subject to a court order for the support of the community spouse, the court-ordered amount of support must be used as the spousal-maintenance-needs deduction when it exceeds the spousal-maintenance-needs deduction calculated according to 130 CMR 520.026(B) or resulting from a fair hearing.

(C) Deductions for Family-Maintenance Needs.

(1) MassHealth allows a deduction from the income of a long-term-care resident to provide for the maintenance needs of the following family members if they live with the community spouse:

(a) a minor child — a child under age 21 of either member of the couple;

(b) a dependent child — a child over age 21 who is claimed as a dependent by either spouse for income-tax purposes under the Internal Revenue Code;

(c) a dependent parent — a parent of either spouse who lives with the community spouse and who is claimed as a dependent by either spouse for income-tax purposes under the Internal Revenue Code; and

(d) a dependent sibling — a brother or sister of either spouse (including a half-brother or half-sister) who lives with the community spouse and who is claimed as a dependent by either spouse for income-tax purposes under the Internal Revenue Code.

(2) The deduction for family-maintenance needs is one-third of the amount by which the federal standard maintenance allowance exceeds the monthly gross income of the family member. The federal standard maintenance allowance is $1,515.

(D) Deductions for Maintenance of a Former Home.

(1) The Division allows a deduction for maintenance of a home when a competent medical authority certifies in writing that a single individual, with no eligible dependents in the home, is likely to return home within six months after the month of admission. This income deduction terminates at the end of the sixth month after the month of admission regardless of the prognosis to return home at that time.

(2) The amount deducted is the 100 percent federal-poverty-level income standard for one person.

(E) Deductions for Health-Care Coverage and Other Incurred Expenses.

(1) Health-Insurance Premiums or Membership Costs. The Division allows a deduction for current health-insurance premiums or membership costs when payments are made directly to an insurer or a managed-care organization.

(2) Incurred Expenses.

(a) After the applicant is approved for MassHealth, the Division will allow deductions for the applicant's necessary medical and remedial-care expenses. These expenses must not be payable by a third party. These expenses must be for medical or remedial-care services recognized under state law but not covered by MassHealth.

(b) These expenses must be within reasonable limits as established by the Division. The Division considers expenses to be within reasonable limits provided they are:

(i) not covered by the MassHealth per diem rate paid to the long-term-care facility; and

(ii) certified by a treating physician or other medical provider as being medically necessary.

(3) Guardianship Fees and Related Expenses. The Division allows deductions from a member's income for guardianship fees and related expenses when a guardian is essential to enable an incompetent applicant or member to gain access to or consent to medical treatment, as provided below.

(a) Expenses Related to the Appointment of a Guardian.

(i) The Division allows a deduction for fees and expenses related to the appointment of a guardian if the guardian's appointment is made for the purpose of:

1. assisting an incompetent applicant to gain access to medical treatment through MassHealth; or

2. consenting to medical treatment on behalf of a MassHealth member.

(ii) The Division allows a deduction for reasonable costs, including attorney fees, as approved by the probate court, not to exceed $500 for the appointment, except as provided in 130 CMR 520.026(E)(3)(a)(iii).

(iii) The Division may allow a deduction, as approved by the probate court, of up to $750 for the appointment when the medical issues before the court are more complex. An example of such complexities includes providing evidence of the need for anti-psychotic medications.

(iv) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(b) Guardianship Services Related to the Application Process.

(i) The Division allows a deduction for fees for guardianship services related to the MassHealth application process when the guardian has been appointed by the probate court to assist an incompetent person with the MassHealth application when the securing of MassHealth benefits is essential for the member to gain access to medical treatment.

(ii) The Division allows a deduction for reasonable costs related to the MassHealth application process, as approved by the probate court, not to exceed $500. In cases where an administrative hearing is held, the total deduction may not exceed $750 for the costs related to the application process and hearing.

(iii) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(c) Guardianship Services Related to the Redetermination Process.

(i) The Division allows a deduction for fees for guardianship services related to the MassHealth redetermination process when the guardian has been appointed by the probate court to assist an incompetent person with securing continued access to medical treatment.

(ii) The Division allows a deduction for reasonable costs related to the MassHealth redetermination process, as approved by the probate court, not to exceed $250. In cases where an administrative hearing is held, the total deduction may not exceed $375 for the costs related to the redetermination process and hearing.

(iii) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(d) Monthly Guardianship Services.

(i) The Division allows a deduction for monthly fees for a guardian to the extent the guardian's services are essential to consent to medical treatment on behalf of the member.

(ii) The Division allows a deduction, as approved by the probate court, for up to 24 hours per year at a maximum of $50 per hour for guardianship services.

(iii) The Division allows the deduction only if the guardianship services provided include the attendance and participation of the guardian in quarterly care meetings held by the nursing facility where the member lives.

(iv) The Division allows this deduction only if each year the guardian submits to the Division a copy of the affidavit that describes the guardianship services provided to the member.

(v) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(e) Expenses Incurred by the Guardian in Connection with Monthly Guardianship Services.

(i) The Division allows a deduction up to, but not exceeding, the member's monthly patient-paid amount for filing and court fees incurred by the guardian in connection with monthly guardianship services that are essential to consent to medical treatment for the member.

(ii) If monthly guardianship services are provided, these expenses are included in the affidavit of services required under 130 CMR 520.026(E)(3)(d)(iv).

(iii) The deduction is made from the member's monthly patient-paid amount in the month following receipt of the affidavit of services.

(f) Hardship.

(i) If exceptional circumstances exist that make the deductions allowed under 130 CMR 520.026(E) insufficient to cover the expenses required for a guardian to provide essential guardianship services needed to gain access to or consent to medical treatment, the guardian, on behalf of the member, may appeal to the Board of Hearings for an increased deduction.

(ii) A hearing officer may allow for an increased deduction for guardianship expenses only in circumstances where the issues surrounding the member's need to gain access to or consent to medical treatment are extraordinary.

(iii) Extraordinary circumstances may exist when:

1. there is a need for a guardian to consistently spend more than 24 hours per year providing guardianship services to appropriately consent to medical treatment needed by the member; or

2. the circumstances of a MassHealth member cause the guardian appointment or application process to be particularly complex and significantly more costly than the deduction allowed at 130 CMR 520.026(E)(3)(a) or (b).

(g) Guardianship Services and Expenses that are not Deductible. The following fees and costs are not allowed as a deduction under 130 CMR 520.026(E).

(i) Amounts that are also used to reduce a member's assets under 130 CMR 520.004.

(ii) Amounts that are also used to meet a deductible or any other deduction allowed under MassHealth regulations.

(iii) Expenses related to the appointment of a guardian for an applicant when the appointment is made more than six months before submission of a MassHealth application.

(iv) Expenses related to the appointment of a guardian for an applicant or member when the applicant or member does not request a deduction for the appointment within six months of the date of application or date of appointment, whichever is later. However, these expenses may be used as allowed pursuant to 130 CMR 506.009 or 520.032 to meet a deductible.

(v) Expenses, fees, or costs for expenses that are not essential to obtain medical treatment for the ward including financial management, except when the management is necessary to accurately complete a MassHealth application or redetermination form.

(vi) Expenses, fees, or costs for transportation or travel time.

(vii) Attorney fees, except when payment of the fees is required for the appointment of the guardian.

(viii) Fees for guardianship services provided by a parent, spouse, sibling, or child, even if appointed by the probate court. However, the Division allows a deduction for guardianship expenses in accordance with 130 CMR 520.026(E)(3)(a) and (e).

520.027: Long-Term-Care Deductible

If after applying the deductions in 130 CMR 520.026(A) through (E) the long-term-care-facility resident's monthly income exceeds the public rate at the long-term-care facility, the Division will establish a six-month deductible in accordance with 130 CMR 520.028 through 520.035 and use an income standard of $60.

520.028: Eligibility for a Deductible

The following individuals may establish eligibility by meeting a deductible:

(A) former SSI recipients who are not eligible under the Pickle Amendment;

(B) community-based individuals whose countable-income amount exceeds the 100 percent federal-poverty-level income standards;

(C) long-term-care-facility residents whose income, after general deductions described in 130 CMR 520.026, exceeds the public rate in a long-term-care facility;

(D) disabled adult children whose incomes exceed the standards set forth in 130 CMR 519.004(A); and

(E) persons who are eligible for an increased disregard as described at 130 CMR 520.013(B).

520.029: The Deductible Period

The deductible period is a six-month period that starts on the first day of the month of application or may begin up to three months before the first day of the month of application. The applicant is eligible for this period of retroactivity only if the applicant incurred medical expenses covered by MassHealth and was otherwise eligible.

520.030: Calculating the Deductible

The deductible is determined by multiplying the excess monthly income by six. Excess monthly income is the amount by which the applicant's countable-income amount as described in 130 CMR 520.009 exceeds the MassHealth deductible-income standard.

MASSHEALTH DEDUCTIBLE-INCOME STANDARDS

Number of Persons	Monthly-Income Standard for Community Residents	Monthly-Income Standard for Long-Term-Care-Facility Residents
1	$522	
2	650	$60

520.031: Notification of Potential Eligibility

(A) MassHealth informs the applicant who has excess monthly income that he or she is currently ineligible for MassHealth Standard, Essential, or Limited but may establish eligibility for a six-month period by meeting the deductible. MassHealth informs the applicant in writing of the following:

(1) the deductible amount and the method of calculation;

(2) the start and end dates of the deductible period;

(3) the procedures for submitting medical bills;

(4) his or her responsibility to report all changes in circumstances that may affect eligibility or the deductible amount; and

(5) that the bills submitted to meet the deductible are the responsibility of the individual and cannot be submitted for MassHealth payment.

(B) A member who has established eligibility based upon meeting a deductible is only eligible for MassHealth Standard, Essential, or Limited until the end of the deductible period. At the end of the deductible period, MassHealth notifies the member in writing of a new deductible period and amount, if the countable-income amount continues to exceed applicable income standards.

520.032: Submission of Bills to Meet the Deductible

(A) Criteria. To establish eligibility by meeting a deductible, the individual must submit verification of medical bills whose total equals or exceeds the deductible and that meet the following criteria.

(1) The bill must not be subject to further payment by health insurance or other liable third-party coverage, including the uncompensated-care pool.

(2) The bill must be for an allowable medical or remedial-care expense in accordance with 130 CMR 520.032(B). A remedial-care expense is a nonmedical support service made necessary by the medical condition of the individual or the spouse.

(3) The bill must be unpaid and a current liability or, if paid, paid during the current six-month deductible period.

(4) Any bill or portion of a bill used to meet a deductible may not be applied to any other deductible period. However, any portion of a bill not used to meet the current deductible may be used in a future deductible period. The Division will not pay any bills or portions of bills that are used to meet the deductible. These bills remain the responsibility of the applicant.

(B) Expenses Used to Meet the Deductible. The Division applies bills to meet the deductible in the following order:

(1) Medicare and other health-insurance premiums credited prospectively for the cost of six months' coverage, deductibles, enrollment fees, or coinsurance charges incurred by the individual and the spouse including copayments imposed under 130 CMR 520.036;

(2) expenses incurred by the individual and the spouse for necessary medical and remedial-care services that are recognized under state law but are not covered by MassHealth, including guardianship fees and related expenses as described in and allowed under 130 CMR 520.026(E)(3); and

(3) expenses incurred by the individual, a family member, or financially responsible relative for necessary medical and remedial-care services that are covered by MassHealth.

(C) Expenses That Cannot Be Used to Meet the Deductible. Expenses that may not be applied to meet the deductible include, but are not limited to, the following:

(1) cosmetic surgery;

(2) rest-home care;

(3) weight-training equipment;

(4) massage therapy;

(5) special diets; and

(6) room-and-board charges for individuals in residential programs.

520.033: Verification of Medical Expenses

(A) Medical expenses must be verified by a bill or written statement from a health-care provider with the exception of expenses for nonprescription drugs, which must be verified by a receipt from the provider of the drug. Any unpaid bill incurred before the deductible period must be verified by a bill dated within the six-month deductible period.

(B) Verifications must include all of the following information:

(1) the name of the provider;

(2) the type of service provided;

(3) the name of the individual for whom the service was provided;

(4) the amount charged for the service including the current balance; and

(5) the date of service.

520.034: Interim Changes

The applicant or member must notify the Division of any changes occurring before meeting the deductible or during the deductible period. These changes include an increase or decrease in income or an increase in assets.

520.035: Conclusion of the Deductible Process

When the total of submitted bills is equal to or greater than the deductible and all other eligibility requirements continue to be met, MassHealth notifies the applicant that he or she is eligible. The member is eligible for payment of all covered medical expenses incurred during that deductible period, other than those submitted to meet the deductible, as long as the member continues to meet all other eligibility requirements during the balance of the deductible period.

520.036: Copayments Required by MassHealth

MassHealth requires MassHealth members to make the copayments described in 130 CMR 520.038, up to the calendar-year maximum described in 130 CMR 520.040, except as excluded in 130 CMR 520.037. If the usual and customary fee for the service or product is less than the copayment amount, the member must pay the amount of the service or product.

520.037: Copayment Requirement Exclusions

(A) Excluded Individuals.

(1) The following individuals do not have to pay the copayments described in 130 CMR 520.038:

(a) members under 19 years of age;

(b) members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15, she is exempt from the copayment requirement until August 1);

(c) MassHealth Limited members;

(d) MassHealth Senior Buy-In members or MassHealth Standard members for Medicare-covered drugs only, when provided by a Medicare-certified provider;

(e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for the mentally retarded or are admitted to hospitals from such facilities;

(f) members receiving hospice services; and

(g) persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106, if they do not receive MassHealth Standard or MassHealth Essential.

(2) Members who have accumulated copayment charges totaling the calendar-year maximum of $200 on pharmacy services do not have to pay further MassHealth copayments on pharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for pharmacy services.

(3) Members who have accumulated copayment charges totaling the calendar-year maximum of $36 on nonpharmacy services do not have to pay further MassHealth copayments on nonpharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for nonpharmacy services.

(4) Members who have other comprehensive medical insurance, including Medicare, do not have to pay MassHealth copayments on nonpharmacy services.

(5) Members who are inpatients in a hospital do not have to pay a separate copayment for pharmacy services provided as part of the hospital stay.

(B) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 520.038:

(1) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;

(2) nonpharmacy behavioral health services; and

(3) emergency services.

520.038: Services Subject to Copayment

MassHealth members are responsible for making the following copayments unless excluded in 130 CMR 520.037:

(A) Pharmacy Services.

(1) $1 for each prescription and refill for each generic drug and over-the-counter drug covered by MassHealth; and

(2) $3 for each prescription and refill for all other drugs covered by MassHealth.

(B) Nonpharmacy Services.

(1) $3 for nonemergency services covered by MassHealth provided in a hospital emergency department; and

(2) $3 for an acute inpatient hospital stay.

520.039: Members Unable to Pay Copayment

Providers may not refuse services to a member who is unable to pay at the time the service is provided. However, the member remains liable to the provider for the copayment amount.

520.040: Calendar-Year Maximum

Members are responsible for the MassHealth copayments described in 130 CMR 520.038, up to the following calendar-year maximums:

(A) $200 for pharmacy services; and

(B) $36 for nonpharmacy services.